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VIA HAND DELIVERY AND FASCIMILE

Commissioner Robert E. Nicolay, Chairman
Certificate of Need Task Force
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: **Comments of the Health Facilities Association of Maryland**

Dear Mr. Nicolay:

Thank you for the opportunity to speak earlier this week to the Certificate of Need Task Force on behalf of the Health Facilities Association of Maryland as a member of it's planning and regulations committee concerning the MHCC's certificate of need process. As I noted during my testimony, HFAM is comprised of nursing homes licensed and regulated by the MHCC as comprehensive care facilities, as well as providers of assisted living and other ancillary services. Of the 260 Maryland nursing homes, over 150 are HFAM members. HFAM members operate approximately 19,000 beds among member facilities. As a result, HFAM members, and HFAM as an organization, play a vital role in the delivery of, and planning for, long term care services in Maryland.

In responding to the MHCC's solicitation of comments and suggestions for improvements to the CON process, we wish to express our appreciation for the hard work in which the MHCC staff is engaged every day. The following comments are offered as part of the collaborative effort established by Mr. Salamon, the Commission's Chair and you at the outset, seeking ways to make this process even more effective and responsive.

Maintain the CON process for comprehensive care facilities.

HFAM supports maintaining a CON process for comprehensive care facilities. This has been a longstanding feature of the health planning process. Even in a state such as Pennsylvania that gave up the CON process, a proxy for it has been established through the Medicaid program.

There is a need for a flexible approach to capital improvements that benefit residents.

Many of Maryland's long term care facilities were constructed 30 or more years ago. They need upgrades and improvements. In some cases, they will need replacement. Sometimes this can occur on the same or an adjacent site. Other times this can only occur at an alternate location still in the same community but a short distance away. Improvements may be required all at once; other times, they may need to be addressed in phases to avoid disruption to residents and continuity of staff and services.

- The capital threshold is far too low. Roof and window repairs, HVAC upgrades and similar costs can easily exceed the threshold for capital expenditures. These are necessary expenditures that sometimes cannot be planned long in advance. There are stricter requirements for fire safety that need to be met. Increasing the threshold will enable facilities to maintain physical plant in keeping with current standards.

- Certain expenditures to improve quality of care should be reviewed without a CON. For example, there is a national initiative to move toward electronic health records or to use other technological advances to improve quality. These expenditures should not require CON review.

- There can be important benefits to permitting approved projects to include a certain amount of "shell space" for future improvements. There can be savings associated with including those plans in current capital projects. Such space often provides a setting in which alternate services can be used. There is even a recent study documenting how nursing homes in particular play an important part in providing resources in disaster preparedness.

- Where a CON is required for a project, there should be a process for expedited review for certain types of projects. For example, if there is no increase in beds associated with a project so that it simply involves a capital expenditure to provide the same services, an expedited review should be available.

- Historically, it was assumed that an efficiently operated CCF would be 95% occupied. There was a 95% occupancy standard in the Medicaid regulations, and there are 95% standards in the State Health Plan's Long Term Chapter. The Medicaid program now recognizes that efficiently operated CCFs may not be occupied at that level. This is a standard that should be evaluated so that it does not operate as a barrier to beneficial capital projects that improve quality of care and quality of life for both residents and staff.

- Where a CON is required, an applicant should be permitted to obtain approval to implement it in phases, even if the cost is below $5 million. If there is a concern about phasing of a particular project this can be addressed in the CON review itself, but there is nothing inherently wrong with phasing any project.

HFAM welcomes the opportunity to discuss planned changes in CON policy.

HFAM believes strongly that there should be a full discussion of important policy developments affecting existing and future providers of long term care services. This should be accomplished through policy and planning discussions, including rulemaking where warranted, before there are new approaches to long term care services implemented by the MHCC. For example:

- In a recent CON ruling there was a statement that even where existing CCF beds are available in the MHCC's inventory, where a CON is sought to use those same beds relocated to elsewhere, that could be deemed an application to "re-implement" existing capacity triggering a need analysis of some kind. If the MHCC intends to adopt new policies affecting the ability of existing providers to use beds already in the MHCC's inventory, we urge a full discussion of those plans for existing providers.

- We have seen changes in the language of health planning, referring less to licensed beds and more to "bed capacity." It is important that there be advance and inclusive discussions with affected providers if there is to be any change to the MHCC's approach to bed capacity that affects the ability of existing CCFs to obtain approval to use their beds in the most effective manner, and in a way that ensures there is revenue to support those improvements.

Nursing Homes are important sources of Community-based services

HFAM members are not simply providers of inpatient comprehensive care; they are substantial resources for assisted living adult day care, dialysis services, rehabilitation services and a host of other supportive services. As we have noted, many providers are exploring ways to improve their facilities. As such, there can be no substantive discussion of community based services without considering how existing resources are used, and how existing providers can be enabled to adapt to changes in delivery models. Efforts to enhance the availability of community based services should complement those efforts, not be in conflict with them.

Also, the MHCC currently has in place a policy that discourages discharge of Medicaid beneficiaries for alternate, community-based settings. CCFs seeking a CON for any purpose, not simply for new beds or capacity, are required to sign a "memorandum of understanding" obligating the facility to attain and maintain a Medicaid occupancy that is at least equivalent to the Medicaid occupancy among facilities at the time of that CON review, by the lesser of that occupancy in the jurisdiction or health planning region. The effect of this requirement is to maintain Medicaid nursing facility residents without discharge to other settings, even as other facilities may be encouraged to do so. There is no problem for members of the community seeking a CCF bed in a Medicaid certified facility and this standard is outdated. It is contrary to efforts to encourage use of community based services.

The closure process needs to be evaluated.

Sometimes, facilities need to be closed. This can occur for a variety of reasons, such as the end of a lease along with a landlord's plan for an alternative

use of the site, an obsolete physical plant or otherwise. Currently, a CON is required to close a health care facility. This does not make sense. Where a facility needs to close, the CON process cannot realistically result in a ruling that a provider must keep it open. We recommend a process for the MHCC to be made aware of closures, but it is unrealistic for the closures to be subject to a full CON.

Also, currently, where there is a need to relocate existing beds in the inventory, two separate CON reviews are needed; one to close the facility and another to relocate the beds elsewhere.

In the past, there was a generation of smaller, older facilities that were able to close, transferring their beds elsewhere for effective use in the community. The MHCC participates in this process, requiring a determination of CON exemption, the request for which enables the MHCC to obtain information about the transfer, and the value paid for the facility, including its right to operate the CCF beds. The value assigned to those beds has been an important component of the process, sometimes funding the wind down, sometimes funding the reconfiguration of the building into an alternate use such as a community-based service or used for other valid purposes. We urge the MHCC not to adopt a restrictive approach that requires those existing beds in the inventory to be justified by a whole new analysis when they are used elsewhere as part of a CON review. To do so would simply provide an incentive to maintain facilities in place when an agreement can be reached for the beds, already existing within the MHCC's inventory, to be effectively used elsewhere.

There is economic value in the health care facilities providers operate that can, and is, used to fund improvements in physical plant and overall care. Market forces have resulted in improvements in long term care services and this has benefited residents. Rather than depriving facilities of that value, the MHCC should continue to provide a framework where there is an incentive for those resources to be moved to more effective settings.

General comments concerning process.

As a final set of comments, HFAM wishes to offer certain suggestions we believe can improve the overall processing of CON applications.

- The State Health Plan should be reviewed and kept updated. This is particularly the case concerning long term care services. HFAM looks forward to participating in an inclusive health planning process that considers how existing resources and expertise can be used effectively.

- We are concerned about the new approach to only a few "lock-step" CON reviews annually. Historically, certain projects required filing according to a published schedule, such as those that would involve a comparative review. Other projects, particularly those that do not involve a comparative review or involve a request for new bed capacity, could be filed at any time. Thereafter, the facility had up to 6 months to file the CON application. Now, CCF projects can only be filed at particular points in the year, and applications are required to be filed 60 days thereafter. This handicaps the MHCC, which is required by law to rule on docketed applications within 90 days, when there is no evidentiary hearing. In this regard, we make the following suggestions:

    - Particularly under the current capital threshold there are projects that should not need to wait to be filed. For example, the need for renovations, weather, anticipated changes in building material costs, all affect when a CON application process is initiated. Renovation and similar projects letters of intent should be capable of being filed at any time.

    - When a LOI is filed, all the applications should not be due on the 60th day. This simply creates a backlog at the MHCC, which is required to provide its initial set of completeness questions a short time thereafter. When there is a scheduled LOI but no comparative review, applications should continue to have up to 6 months to prepare the application, as has been the case for over 20 years in the CON process.

    - The distinction between completeness questions and "additional information" questions should be maintained. When an application has addressed all the criteria, it should be docketed as complete, even if there are additional questions to be answered. Currently, while there is a deadline for nearly every phase in the

CON process, there is no deadline within which the MHCC staff replies to responses to completeness questions.

- A single notice of a filed application should be sufficient. The current regulations call for publication of a notice of a letter of intent, a notice of the filing of an application, and a notice of the docketing of an application. Certain changes triggers "redocketing." This redundant series of notices no longer makes sense where there are schedule reviews. (they previously had a role before there were schedule reviews and one LOI triggered a right to file competing LOI). The notice of the schedule provides notice of the ability to file a CON and the notice of the docketing of the CON application triggers the ability to file "interested party" comments. Are additional notices needed?

- The MHCC rarely holds evidentiary hearings on projects. The regulations permit a request for "oral argument" on an application where there is no evidentiary hearing. But, rarely is there oral argument on an application. We urge consideration of why there should not be oral argument where it is requested.

Thank you for the opportunity to participate in the work of this Task Force. The CON process is an important part of the state's process for considering the current and future needs of Marylanders. HFAM favors (a) a health planning process that reflects current data, (b) updated health planning policies that foster the ability of providers to compete effectively through new and better programs and services, (d) eliminates barriers to providers seeking to improve the physical environment in which quality care is rendered, and (e) enables providers to use the economic value that is in their facilities as a foundation to improve care. We look forward to continued dialogue on these important matters.

Sincerely,

Howard L. Sollins

cc: Ms. Adele Wilzack
Ms. Sheila Mackertich